**White House Conference on Aging**

# Independent Aging Agenda Event

## Post-Event Summary Report

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| **Name of Event:** | *Faith and Health Care: Co-existing in an Elder Rights World – A Dialogue Between Clergy and Health Care Professionals* at the 2005 Elder Rights Conference |
| **Date of Event:** | May 12, 2005 |
| **Location of Event:** | Emerald Pointe Resort and Conference Center<br>Lake Lanier Islands, Georgia |
| **Number of Persons Attending:** | 275 |
| **Sponsoring Organizations:** | Elder Rights & Advocacy Teams, Georgia Department of Human Resources Division of Aging Services |
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### WHCoA Agenda Items D: "Health and Long-Term Living"
### E: "Social Engagement"

**Selected Topics: (D)** Healthy Lifestyles, Prevention, and Disease Management; Delivery of Quality Care by Caregivers; Support of Caregivers; **(E)** Exploring the roles of religious institutions

**Description:** *The Faith and Health Care Dialogue* consisted of a keynote presentation by noted researcher Harold G. Koenig, MD, MSM of Duke University Medical Center. Dr. Koenig has conducted extensive research on the applicability of spirituality and faith upon the outcomes of older adults with chronic and acute illnesses and the impact of spirituality on the well-being of the health of the elderly. He is internationally regarded and on the Board of the *Templeton Foundation,* a preeminent funder of research on faith and healthcare issues.

At the conclusion of his presentation, Dr. Koenig then joined a panel consisting of **Harry S. Strothers, MD**, MMM of the Morehouse School of Medicine and the National Center for Primary Care; **Imam Plemon Tauheed El-Amin**, Masjid Imam of the Atlanta Masjid; **Rabbi Harvey J. Winokur**, D.D., Temple Rabbi of the Temple Kehillat Chaim of Roswell; **Chaplain Elwood H. "Woody" Spackman, Jr**., M.Div., Executive Director for Emory Center for Pastoral Care and Director of Pastoral Services, Emory Healthcare; and **Mr. Forest Harper**, Vice-President of Community Health Advocacy. Additionally, the audience queried panelists and Dr. Koenig and assessed the issue. The facilitated session addressed issues related to:

- The role of faith/spirituality in dealing with serious illness and/or the process of dying;
- Coping in a spiritual environment with a medical problem;
- How health care providers who are "non-religious and/or atheists" deal with the "wishes" of individuals who rely on their "faith" to make health care decisions;

- How a person's religious/spiritual beliefs influences medical decisions towards the end of life and specifically, whether or not to accept/reject medical treatment that the doctor thinks will impact the patient's health;
- How elder rights providers can advocate for clients' rights and "religious" freedom to make health care decisions, especially when their choices, based on their religion, are in conflict with the provider's personal "faith"; and
- Medical Competence vs. Cultural and Religious Comfort.

**Priority Issue #1: Operationalize significant research findings and evidence-based practices that correlate strong faith to improved health outcomes, coping mechanisms and participation in community life.**

***Strategies and Action Steps***

a. Amend the White House Conference on Aging (WHCoA) Annotated Agenda and relevant WHCoA resolutions to incorporate the faith and health care of the faith-based community (FBC) in its Health and Long Term Living section as part of evidenced-based research and best practices of the delivery of health, mental health and social services. Include Healthy Lifestyles, Prevention and Disease Management strategies and public education and outreach to improve the quality of life of older adults.

b. Remove barriers between the clinical world and faith-based community.

c. Educate faith-based community to go beyond "doing good" and to train them in evidenced based practices and concepts that research indicates would yield high efficacy.

d. Target specific models for grant replication and stressing collaboration between the faith-based community and health professionals. This should be the federal government's goal as it programs funding for disease management of chronic illness, healthy lifestyles and prevention.

e. Provide linkages between the WHCoA agenda items of Health and Long Term Living with the Social Engagement section regarding religious institutions on issues of health care.

f. Promote training of interfaith coalitions to build focus on health of older adults in pastoral care and communities.

g. Focus on holistic health outcomes for older adults; see/treat the whole person, not solely the physical health issues.

- **Barriers:**
  - The mutual distrust between science/medicine and religion and a lack of understanding in medical circles regarding religion and in religious circles regarding the priorities of medicine.
  - All faiths have a diverse and, often times, contradictory methodology of how to deal with health and medicine.
  - The perception that a member of the faith-based community will evangelize or otherwise *"try to convert"* an individual against their values or wishes while providing health care support.
- **Solutions:**
  - Establish a dialogue in the community between health and faith professionals with respect on both sides so that patients could feel free to approach either with respect to

health issues. This will allow the older adult the freedom to access information from either community – whatever feels the most comfortable – and be able to reach the same goal (i.e., accurate and unbiased help to address health care concerns).
- Develop a better platform for health professionals who are either trained in religious/faith matters or are inclined that way, and have a strong and healthy relationship with a local religious organization.
- Develop interfaith dialogues similar to Georgia's *Faith and Health Care Dialogue* using a *"spiritual"* perspective for the community at large.

Priority Issue #2: **Train health care professionals, older adults, caregivers, elder rights teams, advocates, and the faith-based communities on the evidenced based findings that strong faith and access to faith yields individuals who fair better on every indicator than those who do not access or are not permitted to access their faith in a health care setting.**

***Strategies and Action Steps***

a. Initiate training for health care professionals who are not spiritually focused to utilize effective practices, such as spiritual assessment, volunteer opportunities, to provide primary care clinicians a link to both faith-based communities and older adults who may not access health care services in traditional settings. Coordinate this training with established health care professionals (i.e., Emory Healthcare, Morehouse School of Medicine, etc.).
b. Conduct additional research to pinpoint best practices and effective strategies for gaining access to faith-based communities; Look at existing models that work *(i.e. Ben Hill United Methodist Church, Faith in Action, Shepherd Care, etc.)*
c. Provide grants for training programs that emphasize faith and health care professional collaborations, partnerships and volunteer organizations.
d. Teach *"spiritual language"* to health care practitioners as it often provides a way to communicate with patients about health care issues. Spiritual language does not evangelize. Spiritual language is essential in the clinical setting.
e. Conduct state and federal government funded pilot projects on faith and health care, such as the Medicare and Medicaid quality improvement efforts, to reach older adults who may not use the traditional health care delivery system.
f. Provide adequate funding and resources to link faith and health with data to improve outcomes for older adults.
g. Provide and encourage opportunities for cross-religion and interfaith training to facilitate and address individuals of different faiths, elder rights dilemmas that arise and clients' health care particularly regarding treatment for terminal illness and end-of-life decisions.

- **Barriers:**
  - The strong and pervasive belief that physicians should leave their spirituality *"at the door"* and approach a patient with a strict and stringent scientific perspective.
- **Solutions:**
  - Erase the perception in government and in health care operations that spirituality/faith does not heal or comfort. Educate stakeholders that health care issues that commenced where technology has no solution may be addressed by the individual accessing their faith. Positive outcomes that have been attained with spirituality outside of healing include pain management, caregiving, coping skills, and comfort.

Priority Issue #3: **Educate public, health care professionals and the faith-based community on culturally competent geriatric care and issues of faith that address chronic disease, faith, and end-of-life care.**

a. Include faith and health care issues in advocacy of evidence-based practices in faith and health care.
b. Educate community and older adults on volunteer opportunities to work with those in need of caregiving or social services, such as *Faith In Action*, *Shepherd Care*, and local faith-based volunteer groups.
c. Provide incentives to older adults and others to provide caregiving and/or social services to remove isolation and care for needs.
d. Educate on end-of-life issues and difficult conversations and the rights of older adults to make informed decisions regarding their health care. Utilize elder rights advocates (i.e. Elderly Legal Assistance Program providers; Long-Term Care Ombudsmen, and others in the Aging Network to achieve this goal.
e. Utilize church organizational structure (bishops, senior adults ministries, etc.) for distribution of training opportunities and outreach activities such as those on Medicare Part D.

- **Barriers:**
  - Health care practitioners are reluctant to respond to the "spirituality" of their patients when they are unaware of the practices of the patient's religion.
  - Health care professionals and individuals in the faith-based community often do not see the vital role each plays in the health and well-being of individuals in their communities.
- **Solutions:**
  - Provide question/answer programs for the uninformed that focus on the challenges in the health care community in dealing with older adults on how a certain faith(s) deals with those same problems and vice versa.
  - Give trainers resources so that the information can be easily disseminated through the health and religious communities, as well as the general public.
  - Target incentives in financing and grant opportunities to help health care professionals accept the fact that an individual is more than just the sum of his or her physicality, but a spiritual human being – to better align their priorities with regard to treatment and pain management. Additionally, through grant opportunities and training, help religious leaders understand treatment options and comfort them with their understanding and beliefs on spiritual and moral matters. Study the efficacy of any funding through performance measurement of the outcomes of individuals within the target program or community.

Priority Issue #4: **Empower elder rights proponents to advocate for clients' rights and "religious freedom" to make health care decisions, especially when their choices, based upon their religion, are in conflict with provider's personal "faith."**

- **Barriers:**
  - Since individuals have various faiths/beliefs, it is invariably difficult to disconnect your own beliefs, or lack thereof, from treatment of a patient who might have their own beliefs.

- **Solutions:**
  - Start with a general use of spiritual language and attempt to allow and encourage the patient to access their own beliefs and verbalize them within the health care capacity. Let the patient take the lead!
  - Involve faith-based communities with government to create *"rituals"* for health care situations. Such rituals are also found in religious communities and could be a sense of familiarity to the patient.
  - Include in training regimens for elder rights advocates and teams.

Priority Issue #5: **Provide culturally competent medical and social services that use best practices regarding spirituality to eradicate health disparities and improve quality of care for older adults. Include the faith-based community in training to ensure that all services are culturally competent.**

- **Barriers:**
  - According to research, there is a disparity in how health care concerns are addressed based upon an individual's race.
  - Removing barriers that are the root cause of individuals being rendered "invisible" by society. Research consistently that demonstrates that health disparities occur due to race, language, age, and gender.
  - The *"Separation of Church and State"* doctrine is perceived to keep government funding from faith-based communities that could potentially provide a better, spiritually-related service than health care professionals.
  - There is an exploding aging demographics without enough corresponding culturally competent providers and services
  - There is a lack of effective and rigorous cultural competency training programs utilized by advocates, caregivers and service providers.
  - There is a lack of training for the faith-based communities and others in culturally competent issues regarding populations that are not within their congregations.

- **Solutions:**
  - Do not weigh one health concern above another if the disparity exists by providing better access to health insurance coverage; additionally understand the sensitivities that concern each faith's interpretations of how health services interact with their beliefs, and accord the health professionals the opportunity to understand and supply various services to serve various physiological traits and faiths.
  - Allow more funding for faith-based communities and greater coordination between government and religious organizations.
  - Focus on a more preventative basis – not *"fixing"* the problem, but preventing the problem from developing.
  - Provide a focus on community, rather than institutional-based care and allow faith-based organizations to have a larger role in caring for such individuals, by providing them with more funds, opportunities, and directives to do so.

**BARRIER TO ALL: Public dollars are becoming scarcer making it more prudent that we find better ways to fund the needed demands of society, necessitating possible spending cuts or raising taxes. It is hard to achieve our goals without adequate funding for education, training, or providing services with access to religious and faith-based organizations unless there is encouragement for those organizations to step-up and volunteer their services (SOLUTION), and we must overcome the public fear of "linking" religion and government.**